	INTERGOVERNMENTAL AGREEMENT (IGA) AMENDMENT	**ARIZONA DEPARTMENT OF HEALTH SERVICES** 1740 W. Adams, Room 303 Phoenix, Arizona 85007 (602) 542-1040 (602) 542-1741 Fax
	Contract No: **ADHS12-007886** Amendment No. **5**	Procurement Officer: Ana Shoshtarikj

Emergency Preparedness Program

Effective July 1, 2014, it is mutually agreed that the Intergovernmental Agreement referenced is amended as follows:

1. Replace Amendment Four (4) Price Sheet with Price Sheet, page Three (3) of this Amendment Five (5). The Total Price Sheet for FY15 is **$200,419.10**.

2. Replace Amendment Four (4) Attachment A with Attachment A, County Requirements and Deliverables Document, pages Four (4) through Nineteen (19), of this Amendment Five (5).

3. Delete in its entirety Contract Terms and Conditions, Provision Eighteen (18), Health Insurance Portability and Accountability Act of 1996 (HIPAA) and replace with the following:

Continued on next page.

Gila County Health Department Contractor Name 5515 S. Apache Avenue, Suite 400 Address Globe AZ 85501 City State Zip	**CONTRACTOR SIGNATURE** Contractor Authorized Signature Printed Name Title
CONTRACTOR ATTORNEY SIGNATURE Pursuant to A.R.S. § 11-952, the undersigned public agency attorney has determined that this Intergovernmental Agreement is in proper form and is within the powers and authority granted under the laws of the State of Arizona. Signature Date Printed Name	This Intergovernmental Agreement Amendment shall be effective the date indicated. The Public Agency is hereby cautioned not to commence any billable work or provide any material, service or construction under this IGA until the IGA has been executed by an authorized ADHS signatory. **State of Arizona** Signed this _____ day of _____ 20_____ Procurement Officer
Attorney General Contract No. P00120143000078**,** which is an Agreement between public agencies, has been reviewed pursuant to A.R.S. § 11-952 by the undersigned Assistant Attorney General, who has determined that it is in proper form and is within the powers and authority granted under the laws of the State of Arizona. Signature Date Assistant Attorney General Printed Name:	Reserved for use by the Secretary of State **Under House Bill 2011, A.R.S. § 11-952 was amended to remove the requirement that Intergovernmental Agreements be filed with the Secretary of State.**

18. Health Insurance Portability and Accountability Act of 1996

18.1 The Contractor warrants that it is familiar with the requirements of HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009, and accompanying regulations and will comply with all applicable HIPAA requirements in the course of this Contract. Contractor warrants that it will cooperate with the Arizona Department of Health Services (ADHS) in the course of performance of the Contract so that both ADHS and Contractor will be in compliance with HIPAA, including cooperation and coordination with the Arizona Department of Administration-Arizona Strategic Enterprise Technology (ADOA-ASET) Office, the ADOA-ASET Arizona State Chief Information Security Officer and HIPAA Coordinator and other compliance officials required by HIPAA and its regulations. Contractor will sign any documents that are reasonably necessary to keep ADHS and Contractor in compliance with HIPAA, including, but not limited to, business associate agreements.

18.2 If requested by the ADHS Procurement Office, Contractor agrees to sign a "Pledge To Protect Confidential Information" and to abide by the statements addressing the creation, use and disclosure of confidential information, including information designated as protected health information and all other confidential or sensitive information as defined in policy. In addition, if requested, Contractor agrees to attend or participate in HIPAA training offered by ADHS or to provide written verification that the Contractor has attended or participated in job related HIPAA training that is: (1) intended to make the Contractor proficient in HIPAA for purposes of performing the services required and (2) presented by a HIPAA Privacy Officer or other person or program knowledgeable and experienced in HIPAA and who has been approved by the ADOA-ASET Arizona State Chief Information Security Officer and HIPAA Coordinator.

All other provisions of this agreement remain unchanged.

PRICE SHEET

Fixed Price July 1, 2014 – June 30, 2015

Description	Quantity	Unit Rate	Extended Price
CDC Deliverables for Public Health Emergency Preparedness - PHEP	1	$200,419.10	$200,419.10
		Total	**$200,419.10**

ATTACHMENT A

PUBLIC HEALTH EMERGENCY PREPAREDNESS

COUNTY REQUIREMENTS & DELIVERABLES DOCUMENT

BUDGET PERIOD 3 (BP3)

Period of performance

(July 1, 2014 – June 30, 2015)

1. INTRODUCTION

1.1 Approaching Budget Period Three (July 1st, 2014 – June 30th, 2015), continuous efforts are made to expand the preparedness capabilities based on the Five-Year Plan and the Capability Planning Guide (CPG) data. Based on the above and the guidance set forth by the Center for Disease Control (CDC), Arizona Department of Health Services (ADHS) has developed the Requirement and Deliverable Document for Counties. The first section of this document outlines the requirements set forth by CDC and ADHS that all County partners shall address and ensure are being met in BP3. The section portion covers the goals, objectives, and outcomes that shall be achieved for each capability within BP3. Progress shall be measured on these goals and objectives throughout the year through frequent communication and mid-year report.

1.2 Table One (1) and Attachment B included herein provide additional information for the County partners.

2. PROGRAM REQUIREMENTS

As a recipient of the Public Health Emergency Preparedness (PHEP) funds from the ADHS, Grantee is required to adhere to Federal and State Grant requirements. Listed below are the Program requirements for the PHEP grant.

3. MEETINGS

3.1 ADHS Sponsored Grant Meetings (Two (2) events annually)

3.1.1 Semi-annual ADHS sponsored All-Partners Workshop meeting shall be attended,

3.1.2 Regional ADHS sponsored Business Meeting shall be attended. ADHS shall hold one Business Meeting in each of the four (4) Healthcare Coalition Regions within the State.

3.2 Healthcare Coalition Meeting

3.2.1 Healthcare Coalition meetings shall be attended in the appropriate region. Regions are divided as following:

3.2.1.1 Northern Region

3.2.1.1.1 County Representatives: Apache County, Coconino County, Navajo County and Yavapai County.

3.2.1.1.2 Tribal Representatives: Hopi Tribe, Navajo Nation and White Mountain Apache Tribe.

3.2.1.2 Western Region

3.2.1.2.1 County Representatives: La Paz County, Mohave County and Yuma County.

3.2.1.2.2 Tribal Representatives: Cocopah Indian Tribe, Fort Mojave Indian Tribe, Kaibab- Paiute Tribe and Quechan Tribe.

3.2.1.3 Central Region

3.2.1.3.1 County Representatives: Gila County, Maricopa County and Pinal County.

3.2.1.3.2 Tribal Representatives: Gila River Indian Community.

3.2.1.4 Southeastern Region

3.2.1.4.1 County Representatives: Cochise County, Graham County, Greenlee County, Pima County and Santa Cruz County.

3.2.1.4.2 Tribal Representatives: Pascua Yaqui Tribe, San Carlos Apache Tribe and Tohono O'odham Nation.

4. FINANCIAL REQUIREMENTS

4.1 Match Requirement

The PHEP award requires a ten percent (10%) "in-kind" or "soft" match from all the grant participants. Each recipient shall include in their budget submission the format they shall use to cover the match and method of documentation. Failure to include the match formula shall preclude funding.

4.2 Inventory

Inventory list shall be provided to ADHS upon request. The Inventory List shall include all capital equipment.

4.3 Budget Allocation

4.3.1 The budget tool developed by ADHS shall be completed, document signed and returned to ADHS for review and approval. ADHS will not release funding to the County until the budget has been approved.

4.3.2 All activities and procurements funded through the PHEP grant shall be aligned with Grantee's budget/spend plan and work plan which should help reaching the goals and objectives outlined in this document. Any items and activities that are not specifically tied to the PHEP program capabilities shall be approved by ADHS before PHEP funds can be utilized on those activities/items.

4.3.3 Counties shall follow the applicable Office of Management and Budget (OMB) Circulars and Cost Principles when developing the budget and throughout the period of performance.

4.4 Grant Activity Oversight

4.4.1 PHEP Coordinator shall be appointed by the County on full or part-time basis.

4.4.2 The PHEP Coordinator shall be the main point of contact for ADHS with the County in regards to the PHEP grant and shall have the responsibility for oversight of all grant related activities.

4.4.3 PHEP Coordinator shall work closely with ADHS to ensure all deliverables and requirements are met.

4.4.4 PHEP Coordinator shall coordinate all activities surrounding any onsite monitoring visits conducted by ADHS.

4.5 Employee Certifications

4.5.1 PHEP Recipients are required to adhere to all applicable Federal laws and regulations, including applicable OMB Circulars and semiannual certification of employees who work solely on a single federal award.

4.5.2 Certification forms shall be prepared semiannually signed by the employee or a supervisory official who has firsthand knowledge of the work performed by the employee.

4.5.3 Split funded employees are required to maintain Labor Activity Reports (to be provided as requested). These certification forms shall be retained in accordance with 45 Code of Federal Regulation, Part 92.42.

4.6 Performance

Failure to meet the deliverables and performance measures described in the Scope of Work shall result in withholding from a portion of subsequent awards.

5. EXERCISES

5.1 Emergency Operation Coordination

5.1.1 Documentation shall be maintained of all collaborative efforts with local and State emergency management.

5.1.2 The County PHEP program shall establish and maintain a collaborative working relationship with emergency management. This shall include but not limited to:

5.1.2.1 Emergency communication plan,

5.1.2.2 Strategies for addressing emergency events, and

5.1.2.3 Consequences management of power failures, natural disasters and other events that would affect public health.

5.1.3 Jointly participate with emergency management in an ADHS sponsored table top, functional exercise or other activity.

5.1.4 Provide documentation to support discussion on the order process in WebEOC.

5.2 Multi-Year Training and Exercise Workshop (MYTEP)

5.2.1 Each County shall attend the annual ADHS Training and Exercise Planning Workshop in June, 2015.

5.2.2 Each County shall submit their final training and exercise plans no later than August 1, 2014.

5.2.2.1 Training and exercise plans shall contain proposed events from July 1, 2014 through June 30, 2019.

5.2.2.2 Plans shall be submitted on the ADHS provided templates.

5.2.2.3 Trainings and exercises shall be gap based. Proposed training and/or exercises shall be based on an identified gap from a previous exercise, response, risk assessment, or other documented source.

6. EXERCISE IMPLEMENTATION CRITERIA

6.1 Homeland Security Exercise and Evaluation Program

Sub-awardees shall conduct preparedness exercises in accordance with the Homeland Security Exercise and Evaluation Program (HSEEP) fundamentals including:

6.1.1 Exercise Design and Development;

6.1.2 Exercise Conduct;

6.1.3 Exercise Evaluation; and

6.1.4 Improvement Planning.

Information on the April 2013 HSEEP guidelines and exercise policy: https://www.llis.dhs.gov/hseep

6.2 ADHS Coordination

6.2.1 To meet the criteria as a qualified exercise, all PHEP sub-awardee exercises shall be coordinated with ADHS and approved prior to the initial planning meeting. ADHS shall be continuously updated throughout the remainder of the planning process.

6.2.2 To comply with the exercise implementation criteria, the HSEEP process and guidance shall be used along with respective templates.

6.3 Healthcare Coalition Exercises

Each Healthcare Coalition (Northern, Central, Western, and Southeastern) shall have an exercise in BP3 that shall require the County's participation. Date shall be determined.

6.4 At-Risk Individuals

6.4.1 Within each exercise, provisions for the needs of at-risk individuals shall be included.

6.4.2 HPP- PHEP sub-awardees shall report on the strengths and areas for improvement identified though the coalition based exercise After Action Report and Improvement Plan (AAR/IP).

6.4.3 U.S. Department of Health and Human Services' definition of "at-risk" population is available at the following website: http://www.phe.gov/Preparedness/planning/abc/Pages/at-risk.aspx

6.5 Exemption

County response and recovery operations supporting real incidents could meet the criteria for this annual exercise requirement if the response was sufficient in scope and the AAR/IPs adequately detail which PHEP capabilities were tested and evaluated. Such situation shall be addressed on an as-requested basis.

6.6 Exercise Evaluation Criteria

6.6.1 PHEP exercise shall address Public Health Preparedness (PHP) Capabilities in all qualifying exercises. If using FEMA Core Capabilities, a cross-walk shall be produced mapping PHP capabilities with core capabilities.

6.6.2 At a minimum, each County shall demonstrate and validate healthcare coalition participation in resource and information management as outlined in the HPP-PHEP aligned capabilities.

6.6.2.1 These capabilities are:

6.6.2.1.1. Capability 3: Emergency Operations Coordination

6.6.2.1.2. Capability 6: Information Sharing.

6.6.3 PHEP Qualifying Exercises:

6.6.3.1 An exercise that meets PHEP-specific qualifying exercise implementation criteria and the specific HPP evaluation criteria.

7. INFORMATION SERVICES

7.1 Access to a secure alerting system that at a minimum has the ability to send email, faxes, and phone/ text alerts is required.

7.2 Each County shall provide to ADHS a list of the system(s) that are utilized in EOC operations and for information sharing during their midyear report.

7.3 Each County shall participate in the Communication Pathway scenarios developed and sent out by ADHS Information Services Group.

7.4 Each County shall be able to utilize the following Communication systems:

7.4.1 HSP

7.4.2 EMResource,

7.4.3 EMTrack,

7.4.4 ESAR-VHP,

7.4.5 AZHAN,

7.4.6 IRMS,

7.4.7 800 radios, and

7.4.8 WebEOC

7.5 Training on the systems and platforms shall be provided by ADHS as needed.

8. REPORTING

Progress on the deliverables, performance measures, and activities funded through the PHEP grant shall be reported in a timely manner, ensuring ADHS has adequate time to compile the information and submit to CDC.

8.1 Mid-Year Report

8.1.1 Mid-Year report templates shall be provided by ADHS in advance of the Due Date.

8.1.1.1 Estimated Due Date is December 2014

8.1.2 CDC Performance Measures templates (if applicable) shall be provided by ADHS in advance of the Due Date.

8.1.2.1 Estimated Due Date shall be determined.

8.1.3 Updated Public Health Emergency Contact list shall be provided to ADHS semi-annually. By each County. The list should include contact information for the primary, secondary, and tertiary individuals for the Public Health Incident Management System (e.g. Incident Commander, Operations, etc.) and posted on the Health Services Portal (HSP).

8.1.3.1 The contact information for each individual shall include:

8.1.3.2.1 Individual's name,

8.1.3.2.2 ICS title,

8.1.3.2.3 Non-emergency position title,

8.1.3.2.4 Telephone numbers (Office, Mobile, and Home), and

8.1.3.2.5 Primary email address.

8.2 Annual Report

8.2.1 Annual Report template shall be provided by ADHS in advance of the Due Date.

8.2.1.1 Due Date shall be determined.

8.3 After Action Report/Improvement Plan

8.3.1 Each County shall submit an AAR/IP for any public health emergency exercise or real world event in which the public health entity participates and has a role.

8.3.2 After a stand-alone DSNS drill, an AAR and an IP shall be provided to the ADHS SNS Coordinator.

8.3.3 AARs shall be submitted to ADHS within sixty (60) days after the exercise.

8.4 Training Validation Reports

A training validation report shall be provided to ADHS by the end of Budget Period Three (3), using the ADHS template located in the HSP. This report shall be a summary of trainings actually conducted in BP3.

9. CAPABILITIES AND COUNTY DELIVERABLES

9.1 CAPABILITY 1: COMMUNITY PREPAREDNESS

Definition: Community preparedness is the ability of communities to prepare for, withstand, and recover in both the short and long terms from public health incidents. By engaging and coordinating with emergency management, healthcare organizations (private and community-based), mental/behavioral health providers, community and faith-based partners, state, local, and territorial, public health's role in community preparedness is to do the following:

9.1.1 Support the development of public health, medical, and mental/behavioral health systems that support recovery;

9.1.2 Participate in awareness training with community and faith-based partners on how to prevent, respond to, and recover from public health incident;

9.1.3 Promote awareness of and access to medical and mental/behavioral health two (2) resources that help protect the community's health and address the functional needs (i.e., communication, medical care, independence, supervision, transportation) of at-risk individuals;

9.1.4 Engage public and private organizations in preparedness activities that represent the functional needs of at-risk individuals as well as the cultural and socio-economic, demographic components of the community; and

9.1.5 Identify those populations that may be at higher risk for adverse health outcomes

9.2 COUNTY DELIVERABLES

9.2.1 Ensure plans include a jurisdictional risk assessment, utilizing an all-hazards approach with input and assistance of the following elements:

9.2.1.1 Public health and non-public health subject matter experts; and

9.2.1.2 Existing inputs from emergency management risk assessment data, health department programs, community engagements, and other applicable sources, that identify and prioritize jurisdictional hazards and health vulnerabilities

9.3 CAPABILITY 2: COMMUNITY RECOVERY

Definition: Community recovery is the ability to collaborate with community partners, (e.g., healthcare organizations, business, education, and emergency management) to plan and advocate for the rebuilding of public health, medical, and mental/behavioral health systems to at least a level of functioning comparable to pre-incident levels, and improved levels where possible.

9.3.1 This capability supports National Health Security Strategy Objective Eight (8): Incorporate Post-Incident Health Recovery into Planning and Response. Post-incident recovery of the public health, medical and mental/behavioral health services, and systems within a jurisdiction is critical for health security and requires collaboration and advocacy by the public health agency for the restoration of services, providers, facilities, and infrastructure within the public health, medical and human services sectors. Monitoring the public health, medical and mental/behavioral health infrastructure is an essential public health service.

9.4 COUNTY DELIVERABLES

Ensure written plans include processes for collaborating with community organizations, emergency management, and health care organizations to identify public health, medical, and mental/behavioral health system recovery needs for the counties identified hazards. Written plans should include the following elements (either as a standalone Public Health Continuity of Operations plan or as a component of another plan):

9.4.1 Definitions and identification of essential services needed to sustain agency mission and operations;

9.4.2 Plans to sustain essential services regardless of the nature of the incident;

9.4.3 Scalable work force reduction; and

9.4.4 Collaborate with ADHS to develop functional exercises in your region to test multiple capabilities including Recovery.

9.4.4.1 Each County shall participate in a regional focused functional exercise in BP3. These exercises shall test your ability to stand up and operate your EOC, recovery operations shall be included to test plans and processes to support Continuity of Operations Plans.

9.5 CAPABILITY 3: EMERGENCY OPERATIONS COORDINATION

Definition: Emergency operations coordination is the ability to direct and support an event or incident with public health or medical implications by establishing a standardized, scalable system of oversight, organization, and supervision consistent with jurisdictional standards and practices and with the National Incident Management System.

9.6 COUNTY DELIVERABLES

9.6.1 Participate in a Functional Exercise conducted within your respective region.

9.6.1.1 Participate in at least one functional exercise to test their ability to stand up and operate their EOC during a public health incident.

9.6.2 Maintain documentation of all collaborative efforts with local and State emergency management.

9.6.3 County/Tribal PHEP program must establish and maintain a collaborative working relationship with emergency management. This must include but not be limited to; Emergency communication plan, strategies for addressing emergency events, including the management of the consequences of power failures, natural disasters and other events that would affect public health.

9.6.4 Jointly participate with emergency management in an ADHS sponsored table top, functional exercise or other activity

9.6.5 Provide documentation to support discussion on the order process in Web-EOC.

9.7 CAPABILITY 4: EMERGENCY PUBLIC INFORMATION AND WARNING

Definition: Emergency public information and warning is the ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management responders.

9.8 COUNTY DELIVERABLES

9.8.1 Participate in the development of Public Information and Warning messaging during a functional exercise.

9.8.1.1 When participating in your regionally based functional exercise, work to develop and disseminate public health messaging and test the communication pathways utilized to communicate that message to the public.

9.9 CAPABILITY 5: FATALITY MANAGEMENT

Definition: Fatality management is the ability to coordinate with other organizations (e.g., law enforcement, healthcare, emergency management, and medical examiner/coroner) to ensure the proper recovery, handling, identification, transportation, tracking, storage and disposal of human remains and

personal effects; certify cause of death; and facilitate access to mental/ behavioral health services to the family members, responders and survivors of an incident.

9.10 COUNTY DELIVERABLES

9.10.1 Participate in the Fatality Management Workshop held by ADHS.

9.10.1.1 Participate in the Fatality Management workshop conducted by ADHS to gain additional insight into the State's and other County's capability to manage mass fatalities and the work each is completing to improve that capability.

9.11 CAPABILITY 6: INFORMATION SHARING

Definition: Information sharing is the ability to conduct multijurisdictional, multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, territorial, and tribal levels of government, and the private sector.

9.12 COUNTY DELIVERABLES

9.12.1 Participate in Communication testing scenarios developed and administered by ADHS.

9.12.1.1 Each County should regularly participate in the Communication testing scenarios to ensure your communication systems and platforms are capable of receiving and disseminating information from the multiple platforms.

9.13 CAPABILITY 7: MASS CARE

Definition: Mass care is the ability to coordinate with partner agencies to address the public health, medical, and mental/behavioral health needs of those impacted by an incident at a congregate location. This capability includes the coordination of ongoing surveillance and assessment to ensure that health needs continue to be met as the incident evolves.

9.14 COUNTY DELIVERABLES

9.14.1 Review and update County's sheltering plan.

9.14.1.1 County shall review and update their plan to support shelter operations in coordination with local Emergency Management. Sheltering plans shall incorporate the needs for At-Risk Individuals and Functional and Access Needs Individuals.

9.15 CAPABILITY 8: MEDICAL COUNTERMEASURE DISPENSING

Definition: Medical countermeasure dispensing is the ability to provide medical countermeasures (including vaccines, antiviral drugs, antibiotics, antitoxin, etc.) in support of treatment or prophylaxis (oral or vaccination) to the identified population in accordance with public health guidelines and/or recommendations.

9.16 COUNTY DELIVERABLES (NON-CRI Counties)

9.16.1 Complete a self-assessment of your county's MCM plan.

9.16.1.1 ADHS shall provide self-assessment template to utilize during your review.

9.16.2 Ensure your County's Receipt, Stage, and Store (RSS) site survey information is current and has been reviewed within the last three (3) years.

9.16.2.1 Provide ADHS your completed self-assessment template, current MCM plan, and current RSS site survey as part of the Mid-Year Report.

9.17 CAPABILITY 9: MEDICAL MATERIEL MANAGEMENT & DISTRIBUTION

Definition: Medical materiel management and distribution is the ability to acquire, maintain (e.g., cold chain storage or other storage protocol), transport, distribute, and track medical materiel (e.g., pharmaceuticals, gloves, masks, and ventilators) during an incident and to recover and account for unused medical materiel, as necessary, after an incident.

9.18 COUNTY DELIVERABLES:

9.18.1 Participate in Inventory Management System quarterly drills.

9.18.2 Cities Readiness Initiative (CRI) Drill Requirement

9.18.2.1 Maricopa County and Pinal County shall conduct at least three (3) different SNS drills utilizing the templates provided by DSNS/ADHS. An executive summary and an improvement plan shall be submitted for each drill.

9.18.2.2 Provide ADHS with the drill results by March 30, 2015

9.18.2.3 List of Drills that can be conducted:

9.18.2.3.1 Staff notification, acknowledgement and assembly;

9.18.2.3.2 Site activation: notification, acknowledgement and assembly;

9.18.2.3.3 Facility Setup;

9.18.2.3.4 Pick List Generation;

9.18.2.3.5 Dispensing Throughput; and

9.18.2.3.6 Public Health Decision Making Tool.

9.19 CAPABILITY 10: MEDICAL SURGE

Definition: Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare system to survive a hazard impact and maintain or rapidly recover operations that were compromised.

9.20 COUNTY DELIVERABLES:

9.20.1 Review/update plans.

9.20.1.1 Written plans should include documentation of staff assigned and trained in advance to fill public health incident management roles as applicable to a given response. Local Health Departments must be prepared to staff emergency operations centers at agency and local levels as necessary. (Local Health Departments shall provide a copy of a PHIMS chart that correlates to the functional drill with local emergency management and the state).

9.20.2 Crisis Standard of Care (CSC) Workshop.

9.20.2.1 Each County is encouraged to participate in the CSC workshop to provide feedback and input on the CSC plan.

9.21 CAPABILITY 11: NON-PHARMACEUTICAL INTERVENTIONS

Definition: Non-pharmaceutical interventions (NPI) are the ability to recommend to the applicable lead agency (if not public health) and implement, if applicable, strategies for disease, injury, and exposure control. Strategies include the following:

9.21.1 Isolation and quarantine;

9.21.2 Restrictions on movement and travel advisory/warnings;

9.21.3 Social distancing;

9.21.4 External decontamination;

9.21.5 Hygiene; and

9.21.6 Precautionary protective behaviors.

9.22 COUNTY DELIVERABLES:

9.22.1 Collaborate with ADHS to develop or review local health department NPI plans.

9.22.1.1 Written plans should include documentation that identifies public health roles and responsibilities related to the jurisdiction's identified risks, that was developed in conjunction with partner agencies (e.g., state environmental health, state occupational health and safety, and hazard-specific subject matter experts) and emergency managers. This documentation should identify the protective equipment, protective actions, or other mechanisms that public health responders shall have to execute potential roles. Roles for consideration may include the following elements:

9.22.1.1.1 Conducting environmental health assessments;

9.22.1.1.2 Potable water inspections; and

9.22.1.1.3 Field surveillance interviews.

9.22.2 Complete the biannual Performance Measure Report Form.

9.22.2.1 Local Health Department shall complete the biannual performance measure report form distributed by ADHS for use in identifying gaps in planning and implementation of interventions in the jurisdiction. Performance measure report information shall be utilized for mid-year and end-of-year grant reporting for PHEP deliverables.

9.23 CAPABILITY 13: PUBLIC HEALTH SURVEILLANCE AND EPIDEMIOLOGICAL INVESTIGATION

Definition: Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

9.24 COUNTY DELIVERABLES

9.24.1 Participate in State Testing of the Communicable Disease On-Call System.

9.24.1.1 Local Department of Health shall participate in tests of the communicable disease on-call system, and shall ensure that sufficient staff are identified and trained to participate in all system tests. Jurisdictions shall complete the disease scenario evaluation form and return to ADHS.

9.24.2 Enter Information into MEDSIS as Required and Provide ADHS Staff with Current Contact Information for MEDSIS Liaisons.

9.24.2.1 Arizona utilizes MEDSIS to conduct reportable disease surveillance. Jurisdictions shall enter information into MEDSIS according to the MEDSIS policies and procedures. Jurisdictions shall maintain a primary MEDSIS liaison and backup and notify ADHS of any changes to the liaison roles or their contact information at the time of the change. MEDSIS liaison responsibilities include requesting/approving new users and notifying ADHS when users no longer require access. The MEDSIS liaison shall also participate in the MEDSIS quarterly meetings.

9.24.3 Conduct Outreach to Delayed Reporters.

9.24.3.1 Local Health Department shall conduct outreach to delayed reporters (entities reporting cases of disease later than timeframes allowed by Arizona Administrative Code). Delayed reporters can be identified through quarterly timeliness reports generated by ADHS or county-specific surveillance activities. Report on the percentage of delayed reporters educated about timeliness of reporting.

9.24.4 Participate in Epidemiology Trainings and Exercises.

9.24.4.1 It is recommended Local Health Department participate in the Epidemiology Surveillance and Capacity (ESC) meetings (at least ten (10) out of twelve (12)), “How to” Presentations (at least eighty percent (80%)) and the Arizona Infectious Disease Training and Exercise. Attendance shall be monitored by ADHS for use in grant reporting.

9.24.5 Conduct Investigations of Reported Infectious Diseases and Public Health Incidents.

9.24.5.1 Local Health Departments shall investigate and report cases of infectious disease as required by Arizona rules and statutes and MEDSIS policies and procedures. Investigation actions should be documented and include the following as necessary: case identification, specimen collection, case investigation/characterization, and control measure implementation. Outbreak investigations should begin within 24hrs of receipt of report. For outbreak cases with a focused questionnaire, interview shall be conducted within 48 hours.

9.24.6 Report All Identified Outbreaks Within 24 Hours.

9.24.6.1 Local Health Departments shall report all identified outbreaks to ADHS within 24 hours utilizing the MEDSIS Outbreak Module; include documentation on outbreak investigation activities as part of jurisdictional mid-year and end-of- year reports to ADHS. At a minimum, include the following information: Outbreak Name, Date Reported to Local Health, Morbidity, Type of Setting, and County of Outbreak Exposure.

9.24.7 Submit Outbreak Summaries to ADHS.

9.24.7.1 Outbreak summaries must be submitted to ADHS utilizing the MEDSIS Outbreak Module within 30 days of outbreak closure for all outbreaks investigated. Summary forms must contain all required minimal elements. **(See Appendix 1)*

9.24.8 Complete the Monthly Performance Measure Report Form.

9.24.8.1 Local Health Departments shall complete the monthly performance measure report form distributed by ADHS for use in identifying gaps in timeliness of reporting, completeness of interviews and monitoring outbreaks in the jurisdiction. Performance measure report information shall be utilized for mid-year and end-of-year grant reporting for both PHEP and ELC grant deliverables.

9.24.9 Conduct Epidemiology Program Evaluations.

9.24.9.1 Recommend Local Health Departments participate in regular meetings and/or conference calls with ADHS regarding evaluation activities by providing feedback and assisting in the refinement of evaluation questions and determining best methods for implementation of findings/recommendations.

9.25 CAPABILITY 14: RESPONDER SAFETY AND HEALTH

Definition: The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.

9.26 COUNTY DELIVERABLES:

9.26.1 Review/update plans to include documentation of the safety and health risk scenarios likely to be faced by public health responders, based on pre-identified jurisdictional incident risks, which are developed in consultation with partner agencies.

9.26.1.1 Plans should include documentation that identifies public health roles and responsibilities related to the jurisdiction have identified risks that were developed in conjunction with partner agencies and emergency managers. This documentation should identify the protective equipment, protective actions, or other mechanisms that public health responders shall have to execute potential roles.

9.27 CAPABILITY 15: VOLUNTEER MANAGEMENT

Definition: Volunteer management is the ability to coordinate the identification, recruitment, registration, credential verification, training, and engagement of volunteers to support the jurisdictional public health agency's response to incidents of public health significance.

9.27.1 Review Volunteer Management plans to ensure processes are identified to manage spontaneous volunteers to include communication pathways, and a method to refer spontaneous volunteers to other organizations.

Table One (1)

DELIVERABLES AT-A-GLANCE

	PROGRAM
1	Attend All Partners Meeting
2	Attend ADHS Business Meeting
3	Attend your Region's Healthcare Coalition Meetings
4	Submit Budget and Work Plan
5	Attend Multi-Year Training and Exercise Workshop (MYTEP)
6	Submit Training and Exercise Plan
7	Have or have access to an Alert System
8	Provide ADHS a list of systems utilized in your EOC and for information sharing
9	Participate in Communication Pathway testing scenarios on a regularly basis
10	Submit Mid-Year and Annual Reports
11	Submit AAR/IPs to ADHS
12	Submit Training Validation Report
	COUNTY
13	Participate in a Functional Exercise to test ability to stand up and operate EOC
14	Participate in the Fatality Management Workshop
15	Review and update Mass Care/Sheltering Plans to incorporate additional measures to address At-Risk and Functional & Access Needs
16	Complete MCM Self-Assessment Tool and Submit MCM Plans to ADHS
17	Review RSS Site Survey and submit to ADHS
18	Participate in quarterly Inventory Management System drills
19	Complete 3 SNS Drills (CRI Counties – Maricopa and Pinal)
20	Collaborate w/ ADHS on NPI plan reviews and to complete bi-annual performance measure report
21	Participate in Epidemiology Trainings and Exercises
22	Conduct investigations, report outbreaks, conduct outreach to delayed reporters, submit summaries of outbreaks, complete monthly performance measure report, & enter info into MEDSIS

ATTACHMENT B

OUTBREAK SUMMARY FORM MINIMAL ELEMENTS

The following elements shall be completed on the ADHS Outbreak Summary Report Form, for the minimal elements to be considered complete:

1. For CONTEXT:
   - 1.1. County of Exposure;
   - 1.2. Case Information: # primary ill; # susceptible;
   - 1.3. Primary setting of exposure; and
   - 1.4. Could etiology be determined.
2. For INITIATION of INVESTIGATION:
   - 2.1. Date LHD first (1st) notified;
   - 2.2. Date ADHS first (1st) notified; and
   - 2.3. Date Investigation started.
3. For INVESTIGATION METHODS:
   - 3.1. Case Definition: Confirmed case; Probable Case; Suspect case (at least one should be filled out);
   - 3.2. Other Actions & Investigation methods: Interviewed cases; Interviewed controls; epi studies; traceback; case/pt samples; environmental samples, environmental health assessment; facility/establishment investigation (at least one should be filled out);
   - 3.3. Were specimens collected; and
   - 3.4. If yes, what is the confirmed etiology.
4. For INVESTIGATION FINDINGS:
   - 4.1. Were specimens collected;
   - 4.2. If yes, what is the confirmed etiology;
   - 4.3. Signs & Symptoms (at least one (1) filled out); and
   - 4.4. Was a specific contaminated food, water or environmental vehicle/source identified?
5. For DISCUSSION and/or CONCLUSIONS:
   - 5.1. Factors Contributing to an Outbreak: Foodborne; Waterborne; Nosocomial; Person to Person; Zoonotic or Vector (*at least one (1)* filled out.)
6. For RECOMMENDATIONS for CONTROLLING DISEASE:
   - 6.1. Outbreak Control section (*at least one(1)* filled out)
7. For KEY INVESTIGATORS:
   - 7.1. Key Investigator section